DIVISION OF EMPLOYMENT SECURITY

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

# CLAIMANT REQUEST FOR APPEAL OF UNEMPLOYMENT INSURANCE DETERMINATION

| Claimant's Name *(Print)* | | Social Security Number |
|---|---|---|
| Date of Determination | Issue Number | Name of Employer |

I appeal this determination. Brief statement explaining why: _____

| Date | Signature |
|---|---|

Mail to:
Division of Employment Security
Appeals Tribunal
P.O. Box 59
Jefferson City, MO 65104

Fax to:
573-751-1321